EXHIBIT 89

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE NATIONAL PRESCRIPTION OPIATE LITIGATION	MDL No. 2804 Case No. 17-MD-2804
This Document Relates to:	Hon. Dan A. Polster
APPLIES TO ALL CASES	

Monday, January 7, 2019

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HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

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Videotaped deposition of CATHERINE JACKSON, held at Foley & Lardner LLP, One Biscayne Tower, 2 Biscayne Boulevard, Suite 1900, Miami, Florida, commencing at 9:27 a.m., on the above date, before Susan D. Wasilewski, Registered Professional Reporter, Certified Realtime Reporter, Certified Realtime Captioner.

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opioids there was appropriate use and disposal and weaning and there is many issues related with opioids, and so we were responsible to make sure that we were doing our part to educate. Our role was, in my opinion, down the chain and small, but whatever we could do to give back to the community was an important piece of what I felt was our responsibility.

Q. And why would you describe your role as "down the chain and small?"

A. Because we -- many people don't utilize -- manufacturers sources of their information, so even though we can put out information, many -- many groups won't even use it because it's got the name of a company.

When you look at the fact that we were -- that we are a manufacturer, it takes so many more steps to get to the patient, so I -- when I say small, I mean it's -- unfortunately we don't have the voice that -- that would allow us to make -- do a lot of work in education and awareness and make a huge impact. So what we do is we do -- we know that there is multifaceted stakeholders involved in any issue and we're one of them. So we do what we can and I feel we should and then everybody else does it

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but we're not the sole source of information.

Q. Okay. And what are some of those things that you said "you do what we can and what you feel you should?"

A. Uh-huh, sure.

Q. What are some of those things?

MR. DAVISON: Objection to form.

A. Patient education, caregiver education, healthcare provider education, and patient education to make sure that they understand whatever disease state, with the course of the disease state, where treatments work in the disease state, how to discuss to their physicians about options when they are getting into trouble with their treatments, when they are no longer working.

For caregivers, it's to help them with resources to give them support, because that is -- for many patients, caregivers play a huge role.

For the healthcare provider, it's ensuring that the products that we manufacture are used in an appropriate way with the appropriate patient. They are dosed appropriately, and then also at the end, that when there is -- when everything -- when the dose -- when the patient is no longer using those medications, are they appropriately taken off, like

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they need to be weaned, different drugs require different ways of stopping. Some you can just stop but not -- especially not opioids.

And then also safe disposal, because we know that there are -- that improper disposal, drugs can lead to diversion.

Q. Okay. So flipping to the section of the slide deck that's the Care Alliance presentation that you would give, this here, as you pointed out, it says managed care team presentation. So do I understand that correctly that it's an internal Mallinckrodt presentation to people who are working on managed care accounts?

A. Yes.

Q. Okay.

A. Exactly.

Q. And what is the CARES Alliance?

A. So the CARES Alliance was a -- the Mallinckrodt had started CARES Alliance in 2010 as their efforts on risk evaluation and mitigation, and so there was no official risk of the REMS program prior to that, which are when Exalgo, which is one of their drugs that was a long-acting pain medication was made, and so the thought at the time was that we really need to have a risk evaluation

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mitigation strategy that we share.

And so that was -- that's CARES Alliance.

Q. Okay. How does -- so is that particular to Exalgo or what's the connection between CARES Alliance and Exalgo?

MR. DAVISON: Objection to form.

A. Exalgo is a drug that was manufactured by the Mallinckrodt section of Covidien, because that was the thing, and so it worked -- it was in the disease state of chronic pain and cancer pain, and so it's really about disease state. The drugs that we manufacture, lead us into the disease states that we work in, if that makes sense, so whatever the FDA approves for the disease state is the areas that we will focus on for advocacy. We have to stay -- we have to really stay in our lanes on disease state because we -- we have -- I often worry that if we go into a different area, that we may be considered -- even though we don't do anything with marketing, marketing off-label. So we stay in the disease state and at the time in 2010, it was in chronic pain and cancer pain.

Q. Okay. And how does that bring about CARES Alliance?

MR. DAVISON: Object to form.

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A. So CARES Alliance was an -- was a -- the idea -- and I can only give you what I was told when I first started the company. So I don't have a lot of detail to that, but Art Morelli and Lisa Saki started CARES Alliance and so it was -- the goal was to be a coalition to collaborate and act responsibly to ensure safety, exactly what it was.

Q. Okay. And what does acting responsibly mean in the context of the CARES Alliance?

MR. DAVISON: Objection to form.

A. I think the same thing that we just discussed, making sure that people are educated about the side effects of drugs, about the -- about proper use, proper disposal, proper management of drugs.

Q. Okay. Flip and look at the next two slides together. So these two slides describe two epidemics. The epidemic of pain and the epidemic of prescription drug abuse.

What's the definition of epidemic?

MR. DAVISON: Objection to form.

A. So epidemic is something that involves the public health of a large group. At this point, it's the United States because this is a -- this was a problem that was going across in different regions,

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a little more than others.

Q. And which epidemic are you speaking about?

A. Both, actually. Yeah, they are both public health issues that we -- unfortunately one affects the other.

Q. And which of these epidemics concerns you more?

MR. DAVISON: Objection to form.

A. Oh, my goodness, as a nurse, the epidemic of pain is devastating. People who have -- I was a pain management nurse for many years at Johns Hopkins and saw people debilitated, unable to hold their kids, unable to hold their jobs, just crushed by chronic pain.

The epidemic of prescription drug abuse is equally upsetting. We have people who are dying and who are turning to opioids for uses other than pain. It's -- both of them are equally disturbing, haunting, and of concern to the medical community.

Q. And personally, if you had a loved one swept up in one of these epidemics, would you rather that loved one be experiencing chronic pain or prescription drug abuse?

MR. DAVISON: Objection to form.

A. I can't answer that.

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Q. Really?

MR. DAVISON: Objection.

Q. Truthfully?

MR. DAVISON: Objection.

A. Truthfully? No, because have you ever had pain? Do you -- I don't know if you've had pain. The kind of pain that's debilitating. [redacted] Luckily, we're blessed that nobody has pain, other than, I think, one of my brothers has chronic back pain, but I think both of them can be debilitating, life ending. People commit suicide due to pain, so I'm not quite sure. Maybe you can explain to me why you seem to be leading me, I'm not quite sure where that's coming from, because I've worked in pain management for 13 years and that's -- you don't get to work in pain without looking at prescription drug abuse, so I've seen both issues in the course of my treatment, I would not want -- I would not wish either one of them on my worst enemy.

Q. If you keep going through the slide, there's a graph showing national rates of opioid overdose deaths, treatment, admissions and sales from 1999 to 2010. The graph shows all three steadily climbing throughout that decade; is that correct?

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A. Yes.

Q. And if the graph were to continue to the present year, we would see the line for opioid overdose death rates continuing to climb; is that correct?

MR. DAVISON: Objection to form.

A. You can't make that statement. I don't know what the data is. I don't know if the data supports your statement.

Q. You personally are not familiar with the overdose death rate annually?

MR. DAVISON: Objection.

A. Not any longer. I haven't done pain medicine, I haven't done advocacy and pain since 2015, so it's been three years since I've actually worked in the area of pain medicine. I'm in the other therapeutic areas of our business.

Q. Your current position at Mallinckrodt is in government affairs and advocacy?

A. It is.

Q. And you would agree that there is a national opioid epidemic currently?

MR. DAVISON: Objection.

A. I would agree that there is definitely a problem with opioid.

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Q. You work for a company that manufactures opioids?
A. Uh-huh.
Q. In the area of government affairs and advocacy, but you're not aware of the opioid overdose death rate?
A. I am not.
MR. DAVISON: Objection to form.
A. No longer, I am not.
Q. When is the last year for which you were aware of it?
MR. DAVISON: Objection to form.
A. It would probably be about 2014, 2015, but I don't remember what it was. I might -- I am now in 10 other therapeutic areas other than pain, so my areas of focus now are off of this and that's my colleague Kevin Webb's area. So we take this very response -- very -- we haven't stepped away from it. We have just changed with who would be focused on it, and it's solely Kevin's area now for advocacy.
Q. Do you ever read news articles about the opioid epidemic?
MR. DAVISON: Objection to form.
A. I do but I can't quote rates.
Q. So you think it may be that the death rate

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has plateaued since 2010?
MR. DAVISON: Objection to form.
A. I can't answer that. I don't know what the numbers are. If you want to share with me another graph, I'd be happy to speak to what is actually happening, but I don't think that's -- I don't want to speak, it could plateau, it could fall a little bit, increase a little bit, it could be -- I don't know.
Q. I just want to make sure that testimony is clear that in your position in Mallinckrodt, you don't know what's happened to overdose death rates since 2010, you think they may have fallen, they may have plateaued, you don't know?
MR. DAVISON: Objection.
A. For the record, I do not know the actual statistics. I do know it's still a national problem but I do not know the statistics, you're absolutely right. I don't know them. I apologize, I don't stay on top of every statistics having to do with it.
Q. Do you stay on top of trends?
A. I -- if it's in my area of working. I mean I stay -- I'm still -- still connected to many people in the pain management, and I would say that

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the trends are that there is increased opioid abuse. I mean -- I'm sorry. That there is continued opioid abuse. I'm not sure how much it's increased or changed from these numbers but I can also tell you that there is a huge trend in patients with pain that are not getting treatment, none, people that are going to the pharmacist with cancer, with other sorts of pain who are unable to get their pain treatment because of this hypervigilance on overdose death.
I think both of them are equally important. I think we absolutely need to do something about both of them, but I do know that there is increased problems on both parts. So -- but I believe now it's not as -- from what I'm reading and this is, once again -- you know, I really, probably, should not answer that because, it's really just my thoughts, but heroin is now also a growing addiction, growing and so this is a very bad situation for this country and for people who are in pain and for people who are addicted.
Q. So you just described as equally important, the undertreatment of pain and opioid overdose deaths. Is that correct?
MR. DAVISON: Objection to form.

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A. So these are two separate issues, but they are both very concerning. They are not -- one is not meant to be put in front of the other. One is not meant to be pushed out and less important. Both of these affect our families, our coworkers, our friends, so it's -- it's a -- I don't have the answers.
Q. Okay. I'm just asking about your testimony. You said, "I think both of them are equally important."
A. I do think they are both equally important.
MR. DAVISON: Objection.
Q. Okay.
A. But they are separate. One does not -- you don't look at one and say, we need to focus on this and ignore that one. Unfortunate -- and we have healthcare people looking at both of these issues.
Q. And given that you are equating the two, personally, would you rather have a loved one waking up in pain every day or going to sleep and never waking up?
MR. DAVISON: Objection to form, asked and answered.
A. I think I've already answered that one for you. I don't want anyone to die, but I also don't

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want someone committing suicide because they can't get out of pain, and that has happened.
Q. Are opioids the only solution for chronic pain?
MR. DAVISON: Objection.
A. Oh, absolutely not. Absolutely not. They are one of multi -- they are one of a multifactorial equation in terms of treating pain. They are just a small piece of it, actually, a very small piece of it.
Q. Okay. Going a couple slides ahead, the heading CARES Alliance here it says "the CARES Alliance aims to improve pain management outcomes through education and awareness campaigns that are innovative and science based? "
A. Yes.
Q. What does that mean, science based?
A. So it's based in research. So we did a couple of programs that, with the -- one was with the American Academy of Family Practice where they actually took the -- took some of the forms that were on CARES Alliance, some of the risk management forms, and then they used them in clinics to identify which patient would be at risk for addiction, so that they could be appropriately

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managed with other therapies than opioids, or they could be watched closer, or whatever it would be that the physician would feel like was important.
So that is evidence -- what we call -- it's actually that's a poor terminology. It really is evidence based --
Q. Evidence based?
A. --is the word that we used. And that means it's research done in a protocol, done strict -- you know, with strict guidelines and it's not just somebody's opinion.
Q. Okay. And who is the audience for the CARES Alliance education and awareness campaigns?
A. Patients, the public, caregivers, healthcare providers, all stakeholders involved in pain.
Q. The next bullet point on the slide says: "Our goal is to help healthcare professionals and people with pain work together to better assess the risks and benefits of pain medications so more people living in pain can find the relief they need."
You mentioned having a background as an RN in practice. What -- given your experience as an RN, what would you say you need to assess the risks and benefits of medications?

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MR. DAVISON: Objection to form.
A. So for drugs like opioids, which can cause -- can -- can be misused, you want to make sure that people -- you have to -- there's all sorts of science based guidelines. You want to look at people who have had a history of addiction, history of misuse, tobacco use is a -- is one of those risk factors, how -- family support, how you -- and I apologize. I don't remember all of them but those are some of the ones that you would do, but opioids are not for everyone. Right? That's the nuance of pain management. But they are used -- for some people they can make the difference between going to work, not going to work, taking care of their kids, not participating. And so we've gotten better and -- in developing tools to help identify those patients that may fall into risks with addiction. It's not a perfect situation but I think we're -- I think that the medical community is doing better and better.
Q. Okay. And you just described the risk information, in terms of balancing risks and benefits. What sort of information would you need to -- on the benefits side, when you are evaluating a medication?

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MR. DAVISON: Objection to form.
A. How does it -- does it -- does it actually help you do something, you know. When people would come into our pain clinic and we would up their dose of any drug, my question was what did you do to -- this -- since we've last met with you, and if they would say, well, nothing, my pain is still 10 out of 10, I would say to them, well, then maybe these drugs are not working for you. You know, it's all about when you are looking at benefit you want reduction in pain, but you also want -- you want someone to bring function back, right? You want people to be able to be participants in their lives. They may not be able to return to work due to injuries beyond -- because of the extent of their injuries, but can they watch their kids, can they get up, take care of the house. Can you -- you don't want people sitting on the couch all day no matter what you are giving them because then you are really not helping.
Q. What about before a person starts to take medication, you're talking about improvements in function after taking a medication, but would you also want to weigh the risks and benefits before someone starts taking the medication at all?